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Amendment No. 1 to SB3137

Southerland
Signature of Sponsor

AMEND Senate Bill No. 3137 House Bill No. 2650*

by deleting all language after the enacting clause and by substituting instead the following:

SECTION 1. Tennessee Code Annotated, Title 56, is amended by deleting Chapter 54, Part 1 in its entirety and by adding Sections 2 through 12 of this act as a new Part 1.

SECTION 2. The title of this act is and may be cited as "The Tennessee Medical Malpractice Reporting Act of 2009."

SECTION 3. This act is intended to ensure the availability of medical malpractice claims data necessary for thorough analysis and understanding of issues associated with medical malpractice claims, in order to support the establishment and maintenance of sound public policy. The information submitted to the department of commerce and insurance pursuant to this section shall be used solely for the purpose of analyzing trends in health care liability claims; provided, however, that the information received pursuant to Section 6 that pertains to judgments and settlements paid as to any medical physician, osteopathic physician or dentist shall be sent to the department of health, division of health related boards and the provisions of Section 8 shall apply to such reports.

SECTION 4.

(a) As used in this act, unless the context otherwise requires:

(1) "Claim" means:

(A) A demand for monetary damages for injury or death caused by medical malpractice; or

(B) A voluntary indemnity payment for injury or death caused by medical malpractice;

(2) “Claimant” means a person, including a decedent’s estate, who is seeking or has sought monetary damages for injury or death caused by medical malpractice;

(3) “Closed claim” means a claim that has been settled or otherwise disposed of by the insuring entity, self-insurer, facility or provider. A claim may be closed with or without an indemnity payment to a claimant;

(4) “Commissioner” means the commissioner of commerce and insurance;

(5) “Companion claims” means separate claims involving the same incident of medical malpractice made against other providers or facilities;

(6) “Economic damages” means objectively verifiable monetary losses, including medical expenses, loss of earnings, burial costs, loss of use of property, cost of replacement or repair, cost of obtaining substitute domestic services, and loss of business or employment opportunities;

(7) “Health care facility” or “facility” means an entity licensed under Title 68, including a clinic, diagnostic center, hospital, laboratory, mental health center, nursing home, office, surgical facility, treatment facility, or similar place where a health care provider provides health care to patients;

(8) “Health care provider” or “provider” means:

(A) A person licensed in either title 63, except chapter 12, or 68 to provide health care or related services including, but not limited to, an acupuncturist, a physician, a surgeon, an osteopathic physician, a dentist, a nurse, an optometrist, a podiatrist, a chiropractor, a physical therapist, a psychologist, a pharmacist, an optician, a physician assistant, a certified

professional midwife, an orthopedic physician assistant, or a nurse practitioner. If the person is deceased, this includes his or her estate or personal representative; or

(B) An employee or agent of a person described in subdivision (A) of this subsection, acting in the course and scope of his or her employment. If the employee or agent is deceased, this includes his or her estate or personal representative;

(9) “Insuring entity” means:

(A) An authorized insurer;

(B) A captive insurer;

(C) A joint underwriting association;

(D) A patient compensation fund;

(E) A risk retention group; or

(F) An unauthorized insurer that provides surplus lines coverage;

(10) “Medical malpractice” means an actual or alleged negligent act, error, or omission in providing or failing to provide health care services;

(11) “Noneconomic damages” means subjective, nonmonetary losses, including pain, suffering, inconvenience, mental anguish, disability, or disfigurement incurred by the injured party, emotional distress, loss of society and companionship, loss of consortium, humiliation and injury to reputation, and destruction of the parent-child relationship; and

(12) “Self-insurer” means any health care provider, facility, or other individual or entity that assumes operational or financial risk for claims of medical malpractice.

SECTION 5. This act shall apply to all medical malpractice claims in this state, regardless of whether or how they are covered by medical professional liability insurance. This act shall not apply to the state or those employed by the state to the extent that their medical malpractice liability is not covered by an insurance entity.

SECTION 6.

(a) For claims closed or open and pending on or after January 1, 2008:

(1) Every insuring entity or self-insurer that provides medical malpractice insurance to any facility or provider in this state must report each medical malpractice claim to the commissioner;

(2) A claim that is covered under a primary policy and one (1) or more excess policies shall be reported only by the insuring entity that issued the primary policy. The insuring entity that issued the primary policy shall report the total amount, if any, paid with respect to the claim, including any amount paid under an excess policy, any amount paid by the facility or provider, and any amount paid by any other person on behalf of the facility or provider;

(3) If a claim is not covered by an insuring entity or self-insurer, the facility or provider named in the claim must report it to the commissioner after a final claim disposition has occurred due to a court proceeding or a settlement by the parties. Instances in which a claim may not be covered by an insuring entity or self-insurer include situations in which:

(A) The facility or provider did not buy insurance or maintained a self-insured retention that was larger than the final judgment or settlement;

(B) The claim was denied by an insuring entity or self-insurer because it did not fall within the scope of the insurance coverage agreement; or

(C) The annual aggregate coverage limits had been exhausted by other claim payments.

(b)

(1) If a court of competent jurisdiction determines that any self-insurer, risk retention group, or unauthorized insurer is exempt from this act due to a federal preemption or other cause, the facility or provider named in a medical malpractice claim must report all data required by this act.

(2) If any self-insurer, risk retention group or unauthorized insurer fails to report information required by this act or asserts a federal exemption or other jurisdictional preemption, the commissioner may, at his or her sole discretion, grant a waiver from the reporting requirements of this act.

(3) In the event that a waiver is granted under subsection (b)(2) of this section, the facility or provider named in a medical malpractice claim must report all data required by this act on behalf of the self-insurer, risk retention group or unauthorized insurer.

(4) In the event of a court determination under subsection (b)(1) or the granting of a waiver under subsection (b)(2) of this section, the self-insurer, risk retention group, or unauthorized insurer must notify covered providers and facilities that they may have reporting responsibilities under this act.

(c) Counsel for claimants asserting claims covered by this section shall provide information about fee arrangements to the commissioner. The information shall include the portion of any settlement or judgment received by claimant's counsel. For the purposes of the levying of civil penalties under Section 10, counsel for claimants who are required to

submit the information outlined in this subsection shall be considered reporting entities under this section.

(d) Beginning in 2009, reports required under subsections (a) and (c) of this section must be filed by March 1. These reports must include data for all claims open and pending as of the last day of the preceding calendar year, and those claims closed in the preceding calendar year and any adjustments to data reported in prior years.

(e) The commissioner may adopt rules that require insuring entities, self-insurers, facilities, providers, and claimant's counsel to submit all required claim data electronically.

SECTION 7. With the exception of reports received pursuant to Section 6(c), reports required under Section 6 of this act must contain the following information in a format and coding protocol prescribed by the commissioner. However, for all open claims, an insuring entity, self-insurer, facility and provider shall only be required to report the information in its possession as of the date of the report. To the greatest extent possible while still fulfilling the purposes of this act, the format and coding protocol shall be consistent with the format and coding protocol for data reported to the National Practitioner Data Bank.

(1) Claim and incident identifiers, including:

(A) A claim identifier assigned to the claim by the insuring entity, self-insurer, facility or provider; and

(B) An incident identifier if companion claims have been made by a claimant.

(2) The policy limits of the medical professional liability insurance policy covering the claim. However, no information concerning policy limits shall be included in the report prepared pursuant to Section 12.

(3) If applicable, the medical specialty of the provider named in the claim.

(4) The type of health care facility where the medical malpractice incident occurred.

(5) The primary location within a facility where the medical malpractice incident occurred.

(6) The geographic location, by city and county, where the medical malpractice incident occurred.

(7) The injured person's sex and age on the incident date.

(8) The severity of malpractice injury using the National Practitioner Data Bank severity scale.

(9) The dates of:

(A) The incident that was the proximate cause of the claim;

(B) Notice to the insuring entity, self-insurer, facility or provider;

(C) Suit, if a suit was filed;

(D) Final indemnity payment, if any; and

(E) Final action by the insuring entity, self-insurer, facility or provider to close the claim.

(10) Settlement information that identifies the timing and final method of claim disposition, including:

(A) Claims settled by the parties;

(B) Claims disposed of by a court, including the date disposed;

(C) Claims disposed of by alternative dispute resolution, such as arbitration, mediation, private trial and other common dispute resolution methods; and

(D) Whether the settlement occurred before or after trial, if a trial occurred;

(11) Specific information about the indemnity payments and defense and cost containment expenses, including:

(A) For claims disposed of by a court that result in a verdict or judgment that itemizes damages:

(i) The total verdict or judgment;

(ii) If there is more than one (1) defendant, the total indemnity paid by or on behalf of this facility or provider;

(iii) Economic damages;

(iv) Noneconomic damages;

(v) Punitive damages, if applicable; and

(vi) Defense and cost containment expenses, including court costs, attorneys' fees, and costs of expert witnesses; and

(B) For claims that do not result in a verdict or judgment that itemizes damages:

(i) The total amount of the settlement;

(ii) If there is more than one (1) defendant, the total indemnity paid by or on behalf of this facility or provider;

(iii) The insuring entity's or self-insurer's best estimate of economic damages included in the settlement;

(iv) The insuring entity's or self-insurer's best estimate of noneconomic damages included in the settlement; and

(v) Defense and cost containment expenses, including court costs, attorneys' fees, and costs of expert witnesses;

(12) The reason for the medical malpractice claim. The reporting entity must use the same allegation group and specific allegation codes that are used for mandatory reporting to the National Practitioner Data Bank.

(13) Any other open or closed claim data the commissioner determines to be necessary to accomplish the purpose of this act and requires by adopting a rule. The commissioner is also authorized by rule to determine certain open or closed claim data to not be necessary for submission to the commissioner.

SECTION 8.

(a) The information submitted to the department of commerce and insurance pursuant to this section shall be confidential, shall not be subject to public inspection, shall not be subject to discovery, subpoena or legal compulsion for release to any person or entity, and shall not be admissible in any criminal, civil or administrative proceeding.

(b) Nothing in this section shall be construed to prevent parties to a liability claim or legal action from entering into a settlement of that claim on a confidential basis. Any such agreement shall be mutually binding on all parties by the terms of the agreement, with the exception that any party required to report under this section shall do so and such reporting shall not be considered a breach of any confidential settlement agreement.

(c) The commissioner may share information received pursuant to this act with the National Association of Insurance Commissioners, other state insurance departments, or other appropriate government entities. However, the commissioner shall not share any data related to an open or pending claim to any other jurisdiction.

SECTION 9. Any cost incurred by the department of commerce and insurance associated with the implementation of title 56, chapter 54 shall be paid out of existing reserves of insurance division of the department of commerce and insurance.

SECTION 10.

(a) The commissioner may assess a civil penalty in the amount of one hundred dollars ($100) per day upon any insuring entity, self-insurer, facility, provider, and claimant's counsel that fails to file a complete filing by the required date, or otherwise fails to comply with this act. Any insuring entity, self-insurer, facility, provider, and claimant's counsel so assessed may request an administrative hearing to contest the assessment of a penalty under this section.

The prevailing party shall be entitled to its costs in bringing or defending the action.

(b) All hearings under this section shall be conducted pursuant to the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

SECTION 11. The commissioner shall adopt any rules needed for implementing the provisions of this act in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5..

SECTION 12. The commissioner shall submit an annual report to the speaker of the senate and the speaker of the house of representatives summarizing the information submitted pursuant to this act. Such annual report shall be submitted on or before November 1 of each year. Any report shall contain aggregate data only and shall not identify any individual health care facility or health care provider. The annual report compiled by the commissioner shall aggregate total settlement and judgment to all health care providers in connection with a single occurrence, provided, that such report shall not contain any claimant's social security number. Such report shall differentiate between health care facilities and health care providers listed in Section 4.

SECTION 13. If any provision of this act or the application of the provision to any circumstances is held invalid, the remainder of this act or the application of the provision to other circumstances shall not be affected.

SECTION 14. This act shall take effect upon becoming law for rulemaking purposes, and on January 1, 2009 for all other purposes the public welfare requiring it.